The Regulation and Quality Improvement Authority

Inspection Report

2 August 2021

Fairfields Care Home

Type of service: Nursing Home
Address: 80a Fair Hill Road, Cookstown, BT80 8DE
Telephone number: 028 8676 6294

Information on legislation and standards underpinning inspections can be found on our website https://www.rqia.org.uk/

1.0 Service information

Organisation/Registered Provider: Care Facilities & Management Ltd **Responsible Individual(s):** Mrs Barbara Haughey	**Registered Manager:** Mr Phillip McGowan **Date registered:** 18 April 2016
Person in charge at the time of inspection: Mr Phillip McGowan	**Number of registered places:** 70 This number includes: • a maximum of 28 patients in category NH-DE in the Church and Spires units to include no more than one named patient in category NH-MP(E) and one named patient in category NH-LD • a maximum of 42 patients in categories NH-I/NH-PH in the Brook, Adelaide and Maine units There shall be a maximum of one named resident receiving residential care in category RC-I within these three units. The home is also approved to provide care on a day basis for five persons.
Categories of care: Nursing (NH): DE – dementia I – old age not falling within any other category PH – physical disability other than sensory impairment MP(E) - mental disorder excluding learning disability or dementia – over 65 years LD(E) – learning disability – over 65 years	**Number of patients accommodated in the nursing home on the day of this inspection:** 68
Brief description of the accommodation/how the service operates: This is a registered nursing home which provides nursing care for up to 70 persons. The home operates two programmes of care, general nursing care on the ground floor and dementia care, within two smaller units on the first floor. A range of bedroom accommodation, sitting rooms and dining rooms are located on both floors.	

2.0 Inspection summary

An unannounced inspection took place on 2 August 2021 from 10.10 am to 3.00 pm. The inspection was completed by two pharmacist inspectors.

This inspection focused on medicines management within the home and assessed progress with any areas for improvement identified since the last medicines management inspection.

Following discussion with the aligned care inspector, it was agreed that the areas for improvement identified at the last care inspection would be followed up at the next care inspection.

3.0 How we inspect

RQIA's inspections form part of our ongoing assessment of the quality of services. Our reports reflect how they were performing at the time of our inspection, highlighting both good practice and any areas for improvement. It is the responsibility of the service provider to ensure compliance with legislation, standards and best practice, and to address any deficits identified during our inspections.

To prepare for this inspection information held by RQIA about this home was reviewed. This included previous inspection findings, incidents and correspondence.

To complete the inspection a sample of medicine related records, the storage arrangements for medicines, staff training and the auditing systems used to ensure the safe management of medicines were reviewed.

During our inspection we:

- spoke to staff and management about how they plan, deliver and monitor the care and support provided in the home
- observed practice and daily life
- reviewed documents to confirm that appropriate records were kept.

4.0 What people told us about the service

We met with one care assistant, four nurses, a nursing sister, the deputy manager and the manager. All staff were wearing face masks and other personal protective equipment (PPE) as needed. PPE signage was displayed.

Staff were warm and friendly and it was evident from their interactions that they knew the patients well. Patients were observed to be relaxing in the foyer, lounges and bedrooms.

Nurses expressed satisfaction with how the home was managed. They said that they had the appropriate training to look after patients and meet their needs. They spoke highly of the support given by management.

In order to reduce footfall throughout the home, the inspectors did not meet with any patients. Feedback methods included a staff poster and paper questionnaires which were provided to the manager for any patient or their family representative to complete and return using pre-paid, self-addressed envelopes. No responses had been received at the time of issuing this report.

5.0 The inspection

5.1 What has this service done to meet any areas for improvement identified at or since last inspection?

Areas for improvement from the last inspection on 27 May 2021		
Action required to ensure compliance with The Nursing Home Regulations (Northern Ireland) 2005		**Validation of compliance summary**
Area for improvement 1 **Ref**: Regulation 13 (4) **Stated:** Second time	The registered person shall review the storage of medicines awaiting disposal to ensure that they are stored securely until they are safely disposed.	**Met**
	Action taken as confirmed during the inspection: Medicines awaiting disposal were observed to be stored securely. Records of disposal were signed by two nurses.	
Area for improvement 2 **Ref**: Regulation 13 (4) **Stated:** Second time	The registered person shall develop and implement a robust system for the safe management of controlled drugs, including denaturing of Schedule 4 (Part 1) controlled drugs, audit and record-keeping.	**Met**
	Action taken as confirmed during the inspection: Satisfactory systems were observed for the management of controlled drugs. Records were maintained to the required standard. Controlled drug balances were checked at each handover and were accurate. Nurses advised that controlled drugs in Schedule 4 Part (1) are denatured prior to disposal. This was recorded in the controlled drug record book and/or disposal book.	

Area for improvement 3 **Ref:** Regulation 13 (4) **Stated:** First time	The registered person must ensure that records for the administration of thickening agents are accurately maintained.	**Met**
	Action taken as confirmed during the inspection: Records for the administration of thickening agents included the recommended consistency level and those reviewed at the inspection were accurately maintained.	
Area for improvement 4 **Ref:** Regulation 13 (4) **Stated:** First time	The registered person should implement a robust audit tool which covers all aspects of the management of medicines. Action plans to address shortfalls should be developed and implemented.	**Met**
	Action taken as confirmed during the inspection: A range of audits were completed by the manager, deputy manager and nursing sisters. Action plans to address any shortfalls were addressed. Nurses maintained running balances for medicines at each administration.	
Area for improvement 5 **Ref:** Regulation 13 (1) (b) **Stated:** First time	The registered person shall ensure that all unwitnessed falls/ potential head injuries are managed in line with best practice guidance and that neurological observations are consistently recorded.	**Carried forward for review at the next inspection**
	Action required to ensure compliance with this regulation was not fully reviewed as part of this inspection and this will be carried forward to the next care inspection.	

Action required to ensure compliance with Care Standards for Nursing Homes, April 2015		Validation of compliance summary
Area for improvement 1 **Ref:** Standard 29 **Stated:** Second time	The registered person shall review the administration of eye preparations and timing of doses to ensure optimal delivery for the patient.	**Met**
	Action taken as confirmed during the inspection: Clear records for the prescribing and administration of eye preparations were observed. Eye drops were observed to be in date.	
Area for improvement 2 **Ref:** Standard 38.3 **Stated:** First time	The registered persons shall ensure that all relevant checks are in place prior to an offer of employment being made.	**Carried forward to the next inspection**
	Action required to ensure compliance with this standard was not reviewed as part of this inspection and this is carried forward to the next inspection.	
Area for improvement 3 **Ref:** Standard 46 **Stated:** First time	The registered person shall ensure a choice of gloves is available for use by staff depending on the care they are providing.	**Carried forward to the next inspection**
	Action required to ensure compliance with this standard was not reviewed as part of this inspection and this is carried forward to the next inspection.	
Area for improvement 4 **Ref:** Standard 4 **Stated:** First time	The registered persons shall ensure that wound records are maintained in accordance with best practice guidance.	**Carried forward to the next inspection**
	Action required to ensure compliance with this standard was not reviewed as part of this inspection and this is carried forward to the next inspection.	

5.2 Inspection findings

5.2.1 What arrangements are in place to ensure that medicines are appropriately prescribed, monitored and reviewed?

Patients in nursing homes should be registered with a general practitioner (GP) to ensure that they receive appropriate medical care when they need it. At times patients' needs will change and therefore their medicines should be regularly monitored and reviewed. This is usually done by a GP, a pharmacist or during a hospital admission.

Patients in the home were registered with a GP and medicines were dispensed by the community pharmacist.

Personal medication records were in place for each patient. These are records used to list all of the prescribed medicines, with details of how and when they should be administered. It is important that these records accurately reflect the most recent prescription to ensure that medicines are administered as prescribed and because they may be used by other healthcare professionals, for example at medication reviews and hospital appointments.

The personal medication records reviewed at the inspection were accurate and up to date. In line with best practice, a second nurse had checked and signed the personal medication records when they are written and updated to provide a double check that they were accurate. Nurses were reminded that where more than one record is in place they should be labelled 1 of 2, 2 of 2 etc.

All patients should have care plans which detail their specific care needs and how the care is to be delivered. In relation to medicines these may include care plans for the management of distressed reactions, pain, modified diets, self-administration etc.

Patients will sometimes get distressed and will occasionally require medicines to help them manage their distress. It is important that care plans are in place to direct staff on when it is appropriate to administer these medicines and that records are kept of when the medicine was given, the reason it was given and what the outcome was. If nurses record the reason and outcome of giving the medicine, then they can identify common triggers which may cause the patient's distress and if the prescribed medicine is effective for the patient.

The management of distressed reactions was reviewed for five patients. Care plans contained limited details on how the patients expressed their distress, known triggers or de-escalation/engagement strategies and two did not reference the medicines prescribed. This information is necessary to direct the required care. Records of prescribing included the parameters for administration and maximum daily dose. The reason for and outcome of administration of these medicines were recorded.

The management of pain was reviewed for four patients. Care plans did not reference why the patient experienced pain and did not provide details of the prescribed medicines. This information must be recorded to ensure effective care delivery for the patient. Nurses advised that pain was assessed regularly throughout the day and at each medicine round. The audits completed at the inspection indicated that pain relieving medicines were administered as prescribed.

The management of diabetes was reviewed for two patients. Records for the prescribing and administration of insulin were accurately maintained. In-use insulin pens were individually labelled and stored at room temperature. However, care plans did not include sufficient detail to direct staff on the action to take if the patient's blood sugar was too low.

Care plans must contain sufficient detail regarding each patient's specific care needs and how the care is to be delivered for the individual patient. This enables each nurse to deliver the required care to each patient in a consistent manner. The findings of the inspection with regards to care planning in relation to distressed reactions, pain management and diabetes was discussed with the nurses on duty, the deputy manager and manager. The improvements noted in relation to care plans observed at the last inspection had not been sustained. An area for improvement was identified.

Some patients may need their diet modified to ensure that they receive adequate nutrition. This may include thickening fluids to aid swallowing and food supplements in addition to meals. Care plans detailing how the patient should be supported with their food and fluid intake should be in place to direct staff. All staff should have the necessary training to ensure that they can meet the needs of the patient.

The management of thickening agents was reviewed for five patients. The most recent speech and language assessments were available and care plans were in place; one required updating following a recent change and it was agreed that this would be completed following the inspection. The current recommended consistency level was recorded on the personal medication records and records for administration were accurately maintained.

5.2.2 What arrangements are in place to ensure that medicines are supplied on time, stored safely and disposed of appropriately?

Medicines stock levels must be checked on a regular basis and new stock must be ordered on time. This ensures that the patient's medicines are available for administration as prescribed. It is important that they are stored safely and securely so that there is no unauthorised access and disposed of promptly to ensure that a discontinued medicine is not administered in error.

All prescribed medicines were available for administration on the day of the inspection. The records inspected showed that the majority of medicines were available for administration when patients required them. However, the records showed that one patient had recently missed six doses of a medicine and another patient missed four doses of one medicine and five doses of a second medicine as the medicines were out of stock. The manager was aware of one of the omissions. The manager should investigate these incidents and submit a report of the findings and action taken to prevent a recurrence to RQIA. Medicines must be available for administration as prescribed. Two areas for improvement were identified.

The medicines storage areas were observed to be securely locked to prevent any unauthorised access. They were tidy and organised so that medicines belonging to each patient could be easily located.

Satisfactory systems were in place for the disposal of medicines.

5.2.3 What arrangements are in place to ensure that medicines are appropriately administered within the home?

It is important to have a clear record of which medicines have been administered to patients to ensure that they are receiving the correct prescribed treatment.

Within the home, a record of the administration of medicines is completed on pre-printed medicine administration records (MARs) or occasionally handwritten MARs. A sample of these records reviewed were found to have been fully and accurately maintained. The records were filed once completed and were readily retrievable for audit/review.

Management and staff audited medicine administration on a regular basis within the home. A range of audits were carried out. The audits completed at the inspection indicated that the majority of medicines were administered as prescribed. However, in addition to the out of stock medicines (Section 5.2.2) audit discrepancies in the administration of five medicines were identified and discussed with the deputy manager and manager for on-going close monitoring.

Controlled drugs are medicines which are subject to strict legal controls and legislation. They commonly include strong pain killers. The receipt, administration and disposal of controlled drugs are recorded in a controlled drug record book. Records for controlled drugs were maintained to the required standard.

5.2.4 What arrangements are in place to ensure that medicines are safely managed during transfer of care?

People who use medicines may follow a pathway of care that can involve both health and social care services. It is important that medicines are not considered in isolation, but as an integral part of the pathway, and at each step. Problems with the supply of medicines and how information is transferred put people at increased risk of harm when they change from one healthcare setting to another.

The management of medicines on admission to the home was reviewed for two patients. Hospital discharge letters had been received and a copy had been forwarded to the patients' GPs. Two nurses had verified and signed the personal medication records and medication administration records to ensure accuracy of transcribing. Medicines had been accurately received into the home and administered in accordance with the most recent directions. The manager advised that nurses follow up any discrepancies in a timely manner to ensure that the correct medicines are available for administration.

5.2.5 What arrangements are in place to ensure that staff can identify, report and learn from adverse incidents?

Occasionally medicines incidents occur within homes. It is important that there are systems in place which quickly identify that an incident has occurred so that action can be taken to prevent a recurrence and that staff can learn from the incident.

The audit system in place helps staff to identify medicine related incidents. The medicine related incidents which had been reported to RQIA since the last inspection were discussed.

There was evidence that the incidents had been reported to the prescriber for guidance, investigated and learning shared with staff in order to prevent a recurrence.

The deputy manager and manager were reminded that the non-administration of medicines due to stock supply issues may affect the health and well-being of a patient and is a medication related incident which must be reported to the prescriber for guidance, the patient/their next of kin and the appropriate authorities including RQIA.

5.2.6 What measures are in place to ensure that staff in the home are qualified, competent and sufficiently experienced and supported to manage medicines safely?

To ensure that patients are well looked after and receive their medicines appropriately, staff who administer medicines to patients must be appropriately trained. The registered person has a responsibility to check that staff are competent in managing medicines and that staff are supported. Policies and procedures should be up to date and readily available for staff.

Staff in the home had received a structured induction which included medicines management when this forms part of their role. Competencies were assessed following induction and annually thereafter.

Records of staff training in relation to medicines management, including induction, update training and competency assessments were available for inspection.

6.0 Conclusion

The inspection sought to assess if the home was delivering safe, effective and compassionate care and if the home was well led.

All areas for improvement identified at the previous medicines management inspection had been addressed. Although three areas for improvement in relation to care planning and stock control of medicines were identified, RQIA is assured that, with the exception of a small number of medicines, patients were administered their medicines as prescribed. The manager was reminded that the improvements made must be sustained.

We would like to thank the patients and staff for their assistance throughout the inspection.

7.0 Quality Improvement Plan/Areas for Improvement

Areas for improvement have been identified where action is required to ensure compliance with The Nursing Home Regulations (Northern Ireland) 2005 and The Care Standards for Nursing Homes, April 2015.

	Regulations	Standards
Total number of Areas for Improvement	4*	3*

* The total number of areas for improvement includes one under the regulations and three under the standards which are carried forward for review at the next inspection.

Areas for improvement and details of the Quality Improvement Plan were discussed with Mr Phillip McGowan, Registered Manager, as part of the inspection process. The timescales for completion commence from the date of inspection.

Quality Improvement Plan

Action required to ensure compliance with The Nursing Home Regulations (Northern Ireland) 2005

Area for improvement 1 **Ref:** Regulation 13 (1) (b) **Stated:** First time **To be completed by:** Immediately and ongoing	The registered person shall ensure that all unwitnessed falls/ potential head injuries are managed in line with best practice guidance and that neurological observations are consistently recorded.
	Action required to ensure compliance with this regulation was not reviewed as part of this inspection and this is carried forward to the next inspection. Ref: 5.1
Area for improvement 2 **Ref**: Regulation 16 (1) (2) **Stated:** First time **To be completed by:** From the date of the inspection	The registered person shall ensure that detailed patient centred care plans are in place from each patient's assessed needs. This is in relation to care plans for distressed reactions, the management of pain and diabetes. Ref: 5.2.1
	Response by registered person detailing the actions taken: Diabetes - the home has a clear Standard Operating Procedure and Policy on Hypoglycaemia as recommended by the British Diabetic Society and RCN. Staff have been advised that if there is a health risk ie:- low blood sugar- care plans must include reference to the SOP along with any individual amendments. In regards other referred too care plans staff have been advised to be as specific as possible regarding the steps in the care process
Area for improvement 3 **Ref**: Regulation 30 **Stated:** First time **To be completed by:** 28 August 2021	The registered person shall investigate the non-administration of medicines due to stock supply issues identified at the inspection. A report of the findings and action taken to prevent a recurrence should be submitted to RQIA. Ref: 5.2.2
	Response by registered person detailing the actions taken: The report has been forwarded to the RQIA regarding the two residents indicated. Both drugs where not non-administration medicines but following an investigation should off been discontinued on the MAR awaiting further medical interentions. Staff have been informed to be clear regarding instructions

Area for improvement 4 **Ref:** Regulation 13 (4) **Stated:** First time **To be completed by:** From the date of the inspection	The registered person shall ensure that medicines are available for administration as prescribed. Ref: 5.2.2, 5.2.3 & 5.2.5
	Response by registered person detailing the actions taken: As above, however, staff have received further instruction on the requirements to order medications or speak to GP when he stock is a =+3 days only
Action required to ensure compliance with Care Standards for Nursing Homes, April 2015	
Area for improvement 1 **Ref:** Standard 38.3 **Stated:** First time **To be completed by:** Immediately and ongoing.	The registered persons shall ensure that all relevant checks are in place prior to an offer of employment being made.
	Action required to ensure compliance with this standard was not reviewed as part of this inspection and this is carried forward to the next inspection. Ref: 5.1
Area for improvement 2 **Ref:** Standard 46 **Stated:** First time **To be completed by:** Immediately and ongoing.	The registered person shall ensure a choice of gloves is available for use by staff depending on the care they are providing.
	Action required to ensure compliance with this standard was not reviewed as part of this inspection and this is carried forward to the next inspection. Ref: 5.1
Area for improvement 3 **Ref:** Standard 4 **Stated:** First time **To be completed by:** Immediately and ongoing	The registered persons shall ensure that wound records are maintained in accordance with best practice guidance.
	Action required to ensure compliance with this standard was not reviewed as part of this inspection and this is carried forward to the next inspection. Ref: 5.1

Please ensure this document is completed in full and returned via the Web Portal*

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